DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 9 9 — 0 1 1

2. STATE: MA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)
Title XIX

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
October 1, 1999

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.250 et seq.

7. FEDERAL BUDGET IMPACT:
a. FFY 2000 $ 1,020,598
b. FFY 2001 $ 1,020,598

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A(2a)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Same

10. SUBJECT OF AMENDMENT:
Non-state Owned Chronic & Rehabilitation Hospital Payment Methods

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Not required under 42 CFR 430.12(b)(2)(i)

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Mark E. Reynolds

13. TYPED NAME:
Mark E. Reynolds

14. TITLE:
Acting Commissioner

15. DATE SUBMITTED:
December 30, 1999

16. RETURN TO:
Bridget Landers
Coordinator
State Plans
Division of Medical Assistance
600 Washington Street, Boston, MA 02111

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
December 30, 1999

18. DATE APPROVED:
May 4, 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
October 1, 1999

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Ronald P. Preston

22. TITLE:
ARA, DMSO, Boston Region

23. REMARKS:

OFFICIAL

FORM HCFA-179 (07-92)

Instructions on Back

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MASSACHUSETTS MEDICAL ASSISTANCE PROGRAM

Methods Used to Determine Rates of Payment for Non-State Owned Chronic Disease and Rehabilitation Hospital Services

I. GENERAL DESCRIPTION OF PAYMENT METHODOLOGY

The following sections describe the methods and standards utilized by the Division of Medical Assistance ("Division") to establish rates of payment by contract, to be effective October 1, 1999 (Rate Year (RY) 2000), for services rendered by chronic disease and rehabilitation hospitals to patients entitled to medical assistance under M.G.L. c. 118E, §1 *et seq.*

A. **Chief Components:** The payment method described in this attachment is a comprehensive per diem rate for each participating hospital. The daily rate covers both routine and ancillary services provided to inpatients. The base year used for both operating and capital cost information was HFY 1993. A composite inflation index was used to update costs from 1993 to 2000. Individual efficiency standards were applied to Inpatient Overhead costs, Inpatient Capital Costs and six (6) Inpatient Direct Ancillary costs.

B. **Patients Transferred from State Facilities:** The following describes the payment method for non-State-Owned Chronic Disease and Rehabilitation Hospital services provided to former patients of Lakeville Hospital, a State-Owned Nonacute Hospital which has been closed.

1. The rate of payment in connection with this state facility closure has been set based on allowable actual costs under the methodology described herein and expenses which must be incurred by a provider in order to serve the particular patients transferred from this state facility. The Division of Health Care Finance and Policy (DHCFP) reviewed the budget costs of the hospital, to which patients were to be transferred, and found them to meet the reasonableness standards of the rate methodology of the Division of Health Care Finance and Policy (DHCFP). Pursuant to such rate setting, the provider must demonstrate that items and services, furnished because of the special needs of the patients transferred, are necessary in the efficient delivery of necessary health care.

C. **Managed Care for Non-State Owned Chronic Disease and Rehabilitation Hospitals:** The Division has established a contractual managed-care program with non-State Owned Chronic Disease and Rehabilitation Hospitals. Contractually, this program was established through the addition of special conditions to the standard Medicaid provider agreement. The intent of the program is to allow Hospitals an opportunity to provide management of the delivery of all Medicaid covered medical services and care needed by the Recipient while an inpatient at the Hospital. Contracted hospitals will have the responsibility to provide or

arrange and pay for all Medicaid covered medical services, except acute inpatient hospital services. Providers with a managed-care program agreement must continue to comply with all applicable laws and regulations, including 42 CFR 431.51, the Recipient free choice of provider right.

D. The following describes the payment methodology for non-State-Owned Chronic Disease and Rehabilitation Hospitals which enter into an agreement with the Division of Medical Assistance (DMA) to offer a managed care program for inpatients and/or outpatients in a facility. To receive such payment, a non-State-Owned Chronic Disease and Rehabilitation Hospital must agree, by contract with the Division of Medical Assistance (DMA), to one of the conditions below.

1. Provide or arrange for all Medicaid covered services, except acute in-patient hospital services, to all Medicaid Recipients who are inpatients of the chronic hospital. The per diem rate shall not exceed the sum of (a) the lowest per diem amount paid by the Medical Assistance Program to a chronic hospital for inpatient care, (b) the average per diem amount paid by the Medical Assistance Program for all other Medicaid services provided to Recipients in such chronic hospital, (c) the average per diem Medicare co-payment and deductible paid by the Medical Assistance Program on behalf of such Recipients, and (d) additional costs incurred by the chronic hospital for (i) offering services on-site which usually are provided only off-site, (ii) providing case management services to Recipients awaiting admission to the chronic hospital and (iii) developing any innovative community long-term care models to which the Division of Medical Assistance (DMA) agrees. Actual payment to the chronic hospital shall be the contracted monthly per diem rate as so described, less any patient paid amounts and or any third party payments. Where the per diem rate does not include the average Medicare co-pay and deductible stated in subsection (c), the facility may separately bill and receive from the Division of Medical Assistance (DMA) an amount equal to the Medicare co-payment and deductible.

2. Provide for certain services to disabled children in a specialty non-acute pediatric hospital. The hospital may provide for both the inpatient and outpatient medical, surgical and dental needs for disabled infants and children. In addition, the hospital will be responsible for the coordination of care with other health care providers and appropriate state and local agencies.

3. Reimbursement will be based on a per diem rate for inpatient services and a per visit rate for outpatient services. The methodology to establish the separate rates will be the following:

a) **Inpatient Per-Diem** = Annual Budget x Percentage of Annual Budget for inpatient services **DIVIDED BY** prior FY actual Medicaid patient days

b) **Outpatient Per-Visit** = Annual Budget x Percentage of Annual Budget for Outpatient Services **DIVIDED BY** prior FY actual Medicaid outpatient visits

4. Actual payment to the non-acute pediatric hospital shall be the contracted per diem and per visit rate as established above paid on a weekly basis. A total of all payments made in the preceding quarter will be determined by the Division of Medical Assistance (DMA). If payment to the hospital in the preceding quarter exceeds the Quarterly Budget by 10%, the hospital must return the difference between the amount of actual payments made for the quarter and the Quarterly Budget amount. If payment to the hospital for the preceding quarter is below the hospital's Quarterly Budget by 10%, the Division of Medical Assistance (DMA) will, for the first two quarters only, reimburse the hospital the difference between the amount of actual payments made for the quarter and up to 10% of the Quarterly Budget amount.

II. DEFINITIONS

Administrative Day (AD). An inpatient day spent in a hospital by a patient who has been identified by a Peer Review Organization (where applicable) or otherwise by the Division of Medical Assistance (DMA) or by the Department of Public Health (DPH), or any combination of these organizations as a patient not requiring hospital level of care.

Administrative Day Per Diem Rate (AD Rate) An all-inclusive daily rate of payment paid to Hospitals for Administrative Days.

Base Year. (1) For Hospital's licensed and/or operated as non-State-Owned Chronic Disease and Rehabilitation Hospitals in Fiscal Year 1993(FY1993), the base year is the Hospital's FY 1993. (2) For Hospital's licensed and/or operated as non-State-Owned Chronic Disease and Rehabilitation Hospitals in FY 1993 but converted a majority of beds to long term care beds during FY 1993, the base year shall be FY 1994 deflated to FY 1993. (3) For Hospital's licensed and/or operated as non-State-Owned Chronic Disease and Rehabilitation Hospitals in FY 1993, but which eliminated a majority of beds and closed the facility and which in subsequent years continued to provide some services in a new location under a new management, the base year is the first cost reporting period of at least twelve months after the Hospital stared to provide the service at the new location.

Chronic Disease and Rehabilitation Hospital (Hospital). A hospital facility licensed by the Massachusetts Department of Public Health under M.G.L. c. 111, §51, with a majority of its beds providing chronic disease services and/or comprehensive rehabilitation services to patients with appropriate medical needs. This definition includes such a facility licensed with a pediatric specialty.

Department of Public Health (DPH). An agency of the Commonwealth of Massachusetts, Executive Office of Health and Human Services established under M.G.L. c. 17,§1.

Direct Cost. The patient care costs of a cost center exclusive of overhead and capital.

Division of Health Care Finance and Policy (DHCFP). An agency of the Commonwealth of Massachusetts, Executive Office of Health and Human Services established under M.G.L. c. 118G,

Division of Medical Assistance (Division). An agency of the Commonwealth of Massachusetts, Executive Office of Health and Human Services established under M.G.L. c. 118E.

Gross Patient Service Revenue. The total dollar amount of a Hospital's charges for services rendered in a fiscal year.

Hospital Fiscal Year (HFY). The fiscal year used by an individual Hospital.

HURM Manual. The Commonwealth of Massachusetts Hospital Uniform Reporting Manual, promulgated by DHCFP under 114.1 CMR 4.00.

Inpatient Services. Routine and ancillary services which are provided to Recipients admitted as patients to a Chronic Disease and Rehabilitation Hospital.

Inpatient Per Diem Rate. An all-inclusive daily rate of payment for any and all Inpatient Services provided to a Recipient by a Hospital.

Medicaid Program (Medicaid). The medical assistance benefit plans administered by the Division pursuant to M.G.L. c. 118E, §1 *et seq.* and 42 U.S.C. §1396 *et seq.* (Medicaid).

New Hospital. A hospital which was not licensed and/or operated as a non-State-Owned Chronic/Rehabilitation Hospital in FY 1993 or which did not report a full year of actual costs in FY 1993.

Overhead. Overhead consists of expenses for fringe benefits, administration, plant maintenance and repairs, plant operations, laundry, housekeeping, cafeteria, dietary, maintenance personnel, nursing administration and in-service education, RN & LPN education, medical staff teaching and administration, post graduate medical education, central service and supplies, pharmacy, medical records, medical care review, and social services.

Recipient. A person determined by the Division to be eligible for medical assistance under the Medicaid Program.

Rate Year (RY). The period beginning October 1 and ending September 30. RY **2000 will begin on October 1, 1999 and end on September 30, 2000**.

III. MEDICAID PAYMENT METHODOLOGY FOR NON-STATE-OWNED CHRONIC DISEASE AND REHABILITATION HOSPITALS

A. Determination of Inpatient Per Diem Rate

The Inpatient Per Diem Rate is an all-inclusive daily rate paid for any and all inpatient care and services provided by a Hospital to a Medicaid Recipient, except for any and all Administrative Days (see Section III C. 1.) . The Inpatient Per Diem Rate is derived using the following method: (a) the sum of a hospital's base year inpatient Operating Cost (Section III, paragraph A. 2.) plus the Adjustments to Base Year Costs (Section III, paragraph A. 4.) is divided by a hospital's base year patient days; plus (b) the Allowance for Inpatient Capital.

1. Data Sources .

   a) The base year for inpatient costs continues to be Hospital Fiscal Year (HFY) 1993. The Division utilized the inpatient costs reported in the HFY 1993 RSC-403 cost report. For hospitals that converted a majority of beds to long-term care beds during HFY 1993, the base year for Inpatient Costs is HFY 1994 deflated to HFY 1993, using a FY 1993 - FY 1994 inflation factor calculated pursuant to the methodology set forth in Section III, paragraph 4. b)

   b) Inpatient costs include only costs incurred or to be incurred in the provision of hospital care and services, supplies and accommodations and determined according to the Principles of Reimbursement for Provider Costs under 42 U.S.C. §§1395 et seq. as set forth in 42 CFR 413 et seq., the Provider Reimbursement Manual, the HURM Manual, and Generally Accepted Accounting Principles.

   c) The calculations use each Hospital's costs and statistics, as adjusted as a result of prior audits or reviews conducted by DHCFP. The Division may also request additional information, data and documentation from a hospital or DHCFP as necessary to calculate rates.

   d) If the specified data source is unavailable or inadequate, the Division will determine and use the best alternative data source and/or it may perform a statistical analysis to ensure comparability of data.

2. Base Year Inpatient Operating Costs Allowable Base Year Inpatient Operating Costs are the sum of allowable Inpatient Direct Routine Costs, allowable Inpatient Direct Ancillary Costs, and allowable Inpatient Overhead Costs as described below.

   a) Inpatient Direct Routine Costs. Inpatient Direct Routine Costs are a hospital's Total Inpatient Routine Costs as adjusted by audit.

b) Inpatient Direct Ancillary Costs. Inpatient Direct Ancillary Costs are calculated as follows :

(1) Inpatient Direct Ancillary Costs are calculated for each ancillary cost center by multiplying the cost for each cost center **times** the ratio of Inpatient Patient Service Statistics to Total Patient Service Statistics . The inpatient direct ancillary costs for the Drug and Medical Supplies cost centers are calculated as follows:

(a) The cost for the Drug cost center is the sum of the Drug cost **plus** the Total Direct Overhead Cost related to Pharmacy. The Inpatient Direct Ancillary Drug cost is calculated by multiplying the above sum **times** the ratio of the inpatient drug patient service statistics to the total drug patient service statistics

(b) The cost for the Medical Supplies cost center is the sum of Medical Supplies cost **plus** the Total Direct Overhead cost related to Central Service/Supplies. The Inpatient Direct Ancillary Medical Supplies cost is calculated by multiplying the above sum **times** the ratio of the inpatient medical supplies patient service statistics to the total medical supplies patient service statistics.

c) Base year costs for the Laboratory, Radiology, Physical Therapy, Speech Therapy, Respiratory Therapy and Occupational Therapy cost centers are adjusted to incorporate efficiency standards. Efficiency standards are determined by ranking Hospitals' unit costs and establishing median unit cost. The median unit costs serves as the efficiency standard for each of these six (6) ancillary cost centers. Hospitals are classified into Chronic Disease and Rehabilitation groupings. The classification of a Hospitals is determined by whether the Hospital provides primarily Chronic disease (longer stay) or rehabilitation services as described in their FY 1994 RSC 420 submission, and the 1989 American Hospital Association Guide, and based on their average length of stay.

d) Separate efficiency standards are determined for chronic hospitals and rehabilitation hospitals.

e) The efficiency standards are determined as follows:

(1) For each cost center, a unit cost is calculated using the HFY 1994 version of the RSC-403 report. To calculate the unit cost, HFY 1994 Inpatient Direct Ancillary Cost, as described in Section III, paragraph 2. b) (1), is **divided** by the corresponding statistics for each cost center (The unit cost for each hospital in the chronic group is ranked from lowest to highest and the median is determined. The median is the efficiency standard for the chronic hospital group.

(2) The unit cost for each hospital in the rehabilitation group is ranked from lowest to highest and the median is determined. The median is the efficiency standard for the rehabilitation hospital group.

(3) If a hospital's FY 1994 unit cost does not exceed the applicable efficiency standard, its HFY 1993 Inpatient Direct Ancillary Cost as calculated pursuant to Section III, paragraph 2. b) (1) is the allowed cost for that cost center.

(4) If a hospital's FY 1994 unit cost exceeds the applicable efficiency standard, the HFY 1993 Inpatient Direct Ancillary Cost for that cost center is adjusted as follows:

(a) Divide the difference between the hospital's FY 1994 unit cost and the efficiency standard by the hospital's FY 1994 unit cost.

(b) Reduce the HFY 1993 Direct Ancillary Costs for that cost center by the resulting percentage.

f) For all other ancillary cost centers, the allowed cost is the HFY 1993 Inpatient Direct Ancillary Cost for that cost center as calculated pursuant to Section III, paragraph 2. b) (1)The sum of the allowed costs for each ancillary cost center constitutes the Total Inpatient Direct Ancillary Cost.

3. Total Inpatient Overhead. Total Inpatient Overhead is calculated by comparing Total Inpatient Overhead to an efficiency standard as described below.

a) HFY 1993 Inpatient Overhead per diem amount is computed for each hospital as follows:

(1) Inpatient Routine Overhead cost is calculated by subtracting Direct Inpatient Routine Cost) from Inpatient Routine Cost after step-down of overhead).

(2) Inpatient Ancillary Overhead Cost is calculated by

(a) Determining the total overhead cost allocated to each ancillary department

(b) Extracting the inpatient portion of the ancillary overhead cost by multiplying the overhead cost allocated to each ancillary department by the ratio of Inpatient Patient Service Statistics) to Total Patient Service Statistics), and

(c) Summing the inpatient portions of the total ancillary overhead cost in each department to obtain the Inpatient Ancillary Overhead Cost.

(d) The sum of Inpatient Routine Overhead and Inpatient Ancillary Overhead is **divided** by HFY 1993 Patient Days. For hospitals that reported costs for Central Service/Supplies and/or Pharmacy, those costs are removed from the overhead costs and reclassified to Ancillary costs pursuant to Section III, paragraph 2. b) (1).

(e) Separate efficiency standards are determined for chronic hospitals and rehabilitation hospitals, as described in Section III, paragraph 2. d).

(f) The Inpatient Overhead Per Diem Cost for each chronic hospital is ranked from lowest to highest and the median is determined. The median is the efficiency standard for the chronic hospital group.

(g) The Inpatient Overhead Per Diem Cost for each rehabilitation hospital is ranked from lowest to highest and the median is determined. The median is the efficiency standard for the rehabilitation hospital group.

(h) If a hospital's Total Inpatient Overhead Per Diem Cost does not exceed the appropriate efficiency standard, its Total Inpatient Overhead Cost is calculated pursuant to Section III, paragraph 3. a)(1) without further adjustment.

(i) If a hospital's Total Inpatient Overhead Per Diem Cost exceeds the appropriate efficiency standard, the hospital's Total Inpatient Overhead Cost is the efficiency standard multiplied by HFY 1993 Patient Days.

4. Adjustments to Base Year Costs.

a) *Substantial Program Change.* For hospitals which converted beds to long term care use or discontinued major services between the base year and Rate Year (RY) 1999, the base year costs shall be adjusted to remove the costs of the services no longer provided.

b) *Inflation.* Total Inpatient Routine Direct Costs, Total Inpatient Ancillary Direct Costs, and Total Inpatient Overhead Costs are adjusted for inflation from base year **1993 through rate year 2000** using a composite index composed of two cost categories: labor and non-labor. The categories are weighted according to the weights used by the Health Care Financing Administration for PPS-excluded hospitals. The inflation proxy for the labor cost category is the Massachusetts Consumer Price Index (optimistic forecast). The inflation proxy for the non-labor cost category is the non-labor portion of the HCFA market basket for hospitals. **The inflation amounts are 1993-1994 Labor: 2.66%, Non-labor: 3.9%; 1994-1995 Labor: 2.40%, Non-labor: 3.8%; 1995-1996 Labor: 2.87%, Non-labor 3.51%; 1996-1997 Labor: 2.22%, Non-Labor: 1.62%; 1997-1998 Labor: 2.348% Non-Labor: 1.598%; 1998-1999 Labor: 2.173% Non-Labor: 1.12% and 1999-2000 Labor: 1.04% and Non-Labor: 0.35%.** The composite inflation index as calculated herein includes a two percent increase, in conformance with prior years' rate calculations.

c) *Hospital-Specific Adjustments.* If the Division of Health Care Finance and Policy granted a hospital-specific adjustment for costs related to an increase in case mix intensity, in accordance with the regulation in effect for RY 1997, that adjustment has been included. The adjustments granted in RY 1997 by the Division of Health Care Finance and Policy were the following hospital-specific adjustments:

(1) Jewish Memorial Hospital $ 41.91/per day
(2) New England Sinai Hospital $ 44.64/per day
(3) Massachusetts Respiratory Hospital $ 43.28/per day
(4) Spaulding Rehabilitation Hospital $ 29.77/per day

5. Allowance for Inpatient Capital

a) Each Hospital's base year capital costs consist of the hospital's actual HFY 1993 patient care capital requirement for historical depreciation for building and fixed equipment; reasonable interest expenses; amortization and; leases and rental of facilities, subject to the limitations described below. For Hospitals which converted a majority of their beds to long-term care beds during FY 1993, allowable base year capital costs consist of the Hospital's actual FY 1994 patient care capital requirement deflated to FY 1993 using a FY 1993 - FY 1994 inflation factor calculated pursuant to the methodology set forth in Section III1, paragraph 4.b).

b) The limitations applicable to base year capital costs are:

(1) Interest expense attributable to balloon payments on financed debt are excluded. Balloon payments are those in which the final payment on a partially amortized debt is scheduled to be larger than all preceding payments.

(2) Where there was a change of ownership after July 18, 1984, the basis of the fixed assets used in the determination of depreciation and interest expense is the lower of the acquisition cost to the new owner or the basis allowed for reimbursement purposes to the immediate prior owner. The depreciation expense is calculated using the full useful lives of the assets.

(3) All costs (including legal fees, accounting, and administrative costs, travel costs, and the costs of feasibility studies) attributable to the negotiation or settlement of the sale or purchase of any capital asset after July 18, 1984 (by acquisition or merger), for which payment has previously been made by any payer, and which have been included in any portion of prior years' rates, are subtracted from capital costs.

c) Each Hospital's base year inpatient unit capital cost equals the base year inpatient capital cost divided by the base year routine patient days. The base year inpatient unit capital cost is multiplied by a HFY 1993 to RY 1996 inflation factor, using a composite index composed of two cost categories: labor and non-labor. These categories are weighted according to the weights used by the Health Care Financing Administration for PPS-excluded hospitals. The inflation proxy for the labor cost category is the Massachusetts Consumer Price Index. The inflation proxy for the non-labor cost category is the non-labor portion of the HCFA market basket for hospitals. The result is then adjusted by the HCFA Capital Input Price Index for FY 1996 to FY 1997 of 1% and FY 1997 to FY 1998 of 1.13%, and FY 1998 to FY 1999 of .08% to determine the **RY 1999** inpatient unit capital cost.

d) **For RY 2000**, the inpatient unit capital costs of all Chronic Disease and Rehabilitation Hospitals are ranked from lowest to highest and a median is determined. The median is the efficiency standard that serves as the Allowance for Inpatient Capital for RY 2000.

B. **Determination of Inpatient Rate for New Hospitals and Hospitals which Closed a Majority of Beds and Now Provide Some Services in a New Location under New Management, and Merger of Hospitals.**

1. Hospitals licensed before October 1, 1997. For Hospitals which were not licensed and/or operated as a Chronic Disease and Rehabilitation Hospital in FY 1993; were not open for a full year in FY 1993 and did not report a full year of actual costs in FY 1993; or were licensed and/or operated as a Chronic Disease and Rehabilitation Hospital in FY 1993 but eliminated a majority of beds and closed the facility and in subsequent years continued to provide services in a new location and under new management their rates are calculated as follows:

   a) For chronic hospitals, the allowable routine, ancillary, overhead, and capital per diem costs are established at the median of the HFY 1993 per diem costs reported by comparable chronic hospitals.

   b) For rehabilitation hospitals, the allowable routine, ancillary, overhead and capital per diem costs are established at the 75th percentile of the HFY 1993 per diem costs reported by comparable rehabilitation hospitals.

   c) The allowable per diem costs are updated by the inflation factor calculated pursuant to Section III, paragraph 4. b) and paragraph 5. d).

2. Hospitals licensed after October 1, 1997.

   a) The allowable overhead and capital per diem costs will be established at the efficiency standards as calculated pursuant to Section III, paragraph 3. and Section III, paragraph 5. d), respectively.

   b) The allowable routine and ancillary per diem costs will be established at the median of HFY 1993 per diem costs reported by chronic and rehabilitation hospitals.

   c) The allowable per diem costs will be updated by the inflation factor calculated pursuant to Section III, paragraph 4. b) and paragraph 5. d).

3. **Merger of Hospitals**

   Where two chronic disease and/or rehabilitation hospitals merge into a single chronic disease and/or rehabilitation hospital, the RY 2000 per diem is a weighted average based upon projected per diem rates of ech hospital, and fiscal year 1993 total days of each hospital.

C. **Determination of Rate for Administrative Day Patients.**

1. A Hospital will be paid for Administrative Days using an Administrative Day Per Diem Rate (AD Rate). The AD Rate is an all-inclusive daily rate paid for each Administrative Day. The AD Rate is composed of three components: a statewide AD routine per diem amount, a statewide AD ancillary per diem amount and a Hospital-specific supplementary per diem amount. The statewide AD routine per diem amount is derived from the weighted average Medicaid payment rate for case mix category T (10) patients in nursing facilities in 1996. The statewide AD ancillary per diem amount is derived from the statewide weighted average Medicaid ancillary payment for AD patients in Chronic and Rehabilitation Hospitals in FY 1996. The sum of the statewide AD routine and ancillary per diem amounts for RY 2000 is $254.14. For RY 2000, the supplementary per diem amount for each Hospital is the difference between the statewide AD routine and ancillary per diem amount of $254.14 and each Hospital's RY 2000 Inpatient Per Diem Rate .

IV. PAYMENT ADJUSTMENT FOR DISPROPORTIONATE SHARE HOSPITALS

None of the non-State-Owned Chronic/Rehabilitation Hospitals in the Commonwealth offer obstetric services. In accordance with Section 1923 of the Social Security Act (42 U.S.C. 1396r-4), the Commonwealth will make payment adjustments to nonacute hospitals which serve a disproportionate number of low-income patients. Eligibility requirements and the methodology for calculating the adjustment are described below.

A. Determination of Eligibility

A non-State-Owned Chronic/Rehabilitation Hospital is eligible for a disproportionate-share adjustment if:

1. the hospital's Medicaid inpatient utilization rate is at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the state; or

2. the hospital's low-income utilization rate exceeds twenty-five percent (25%) and,

3. to qualify for any type of disproportionate payment adjustment, a hospital must have a medical, inpatient utilization rate, calculated by dividing Medicaid patient days by total patient days, of not less than one percent (1%).

B. Payment Adjustment

1. The total of all disproportionate share payments awarded to a particular hospital under this section shall not exceed the costs incurred during the year of furnishing hospital services to individuals who either are eligible for Medicaid or have no health insurance or source of third party coverage, less payments by Medicaid and by uninsured patients. No hospital will be paid more than the sum of Medicaid unreimbursed costs and free care of that hospital. If an audit reveals that payments in any rate year exceed this sum for a particular hospital,

the excess payments would be returned or offset against disproportionate share payments to the hospital for subsequent rate years.

a. The total amount of funds allocated for payment to Nonacute hospitals including Chronic/Rehabilitation, Psychiatric and State-Owned Nonacute hospitals under the federally-mandated Medicaid disproportionate share adjustment requirement shall be $150,000 per year.

2. The total amount of funds to be allocated for each year will be distributed amongst the qualifying non-State-Owned Chronic/Rehabilitation Hospitals for that year, in accordance with the determination of eligibility described in Section IV. A. above. The distribution of these funds will be made according to the following methodology: For each hospital which qualifies under 1.a. above:

a. the relative ratio of a hospital's Medicaid inpatient utilization rate to one standard deviation of the mean Medicaid inpatient rate for hospitals receiving Medicaid payments in the state will be calculated;

b. a non-State-Owned Chronic/Rehabilitation Hospital's relative ratio as determined above will be multiplied by a base amount in order to determine the payment adjustment amount for that nonacute hospital. The base amount shall be calculated such that the distribution of funds among qualifying hospitals under Section IV.A. above, shall equal the amount specified in Section IV.B.1.a.

Example: The mean Medicaid inpatient utilization rate in the state is 0.45 with a standard deviation (std) of .07. No hospital shall be eligible unless the criterion set forth in section IV A. above are met.

(A) Qualifying Hospitals	(B) Medicaid Inp. Util. Rate	(C)** Ratio of Hosp. Med. Util. Rate to Mean plus std*	Payment Adjustment
A	0.55	1.0577	10,275.02
B	0.60	1.1538	11,208.58
C	0.69	1.3270	12,891.13
D	0.71	1.3654	13,264.16
		TOTAL:	$47,638.89

* Mean (0.45) + std (.07) = 0.52.

** FY 1989 base amount equals $8,468.98; FY 1990 base amount equals $16,937.96; FY 1991 base amount equals $25,406.94 FY 1992 base amount equals $14,571.74; FY 93 base amount equals $9,714.49

o for each hospital which qualifies under IV.A.(2) but not IV.A.(1) above:

A base amount of the total allocated amount specified in a. above, plus an additional amount, calculated on the base and proportionate to the amount that such hospital's low income

utilization rate exceeds twenty-five percent, shall be determined.

Example: Five hospitals' low-income utilization rates are at or above 25% and such hospitals do not qualify under IV.A.(1) above. One hospital's low income utilization rate is 25%, while the rest exceed the 25% rate.

(1) Qualifying Hospitals	(2) Low Income Util. Rate	(3) Ratio of Low Inc. Util. Rate	(4) Payment Adjustment*
A	.25	1.00	$14,571.74
B	.26	1.01	14,717.45
C	.31	1.06	15,446.04
D	.40	1.15	16,757.50
E	.42	1.17	17,048.93
			$78,546.66

* FY 1992 base amount equals $14,571.74

** Total for hospitals qualifying under either IV.A.(1) or (2) equals $150,000 as specified in IV.B.1.a. If the hospital qualifies under both criteria no additional payment is make beyond what the hospital receives pursuant to the first criterion.

C. Pediatric Outlier: For Infants Under One Year of Age

1. In accordance with section 1902 of the Social Security Act, as amended by Section 4604 of OBRA 90, effective July 1, 1991, the Commonwealth will make an annual payment adjustment to non-State-Owned Chronic/ Rehabilitation Hospitals for inpatient hospital services furnished to infants under one year of age involving exceptionally high costs or exceptionally long lengths of stay.

2. Determination of Eligibility. Determination of eligibility for infants under one year of act shall be made as follows:

   a. Exceptionally long lengths of stay.

      (i) First calculate the statewide weighted average Medicaid inpatient length-of-stay. This shall be determined by dividing the sum of Medicaid days for all non-State-Owned Chronic/Rehabilitation Hospitals in the state.

      (ii) Second, calculate the statewide weighted standard deviation for Medicaid inpatient length-of-stay statistics.

      (iii) Third, add one and one-half times the state wide weighted standard deviation for Medicaid inpatient length-of-stay to the state wide weighted average Medicaid inpatient length-of-stay. Any stay equal to or lengthier than the sum of these two numbers shall constitute and exceptionally long length-of-stay for purposes of payment adjustments under this section.

b. Exceptionally High Cost. For each non-State-Owned Chronic/Rehabilitation Hospital providing services on or after July 1, 1991 to individuals under one year of age the Commonwealth shall:

(i) First, calculate the average cost per Medicaid inpatient discharge for each hospital;

(ii) Second, calculate the standard deviation for the cost per Medicaid inpatient discharge for each hospital;

(iii) Third, add one and one-half times the hospital's standard deviation for the cost per Medicaid inpatient discharge to the hospital's average cost per Medicaid inpatient discharge. Any cost which equals or exceeds the sum of these two numbers shall constitute an exceptionally high cost for purposes of payment adjustments.

(a) The amount of funds allocated shall be twenty five thousand dollars ($ 25,000) for FY 2000. This includes Chronic/Rehabilitation, Psychiatric and State-Owned Nonacute hospitals.

(b) Any Hospital which qualifies for a payment adjustment for infants under one shall receive one percent of the total funds allocated for such payments. In the event that the payments to qualifying non-State-Owned Chronic/Rehabilitation Hospitals would exceed the total, each share shall be proportionately reduced to stay within the allocation.

D. Children Under Six

1. Eligibility for Payment. Consistent with section 4604 of the Omnibus Reconciliation Act of 1990 (OBRA 90) outlier adjustments for medically necessary inpatient hospital services, effective July 1, 1991, involving exceptionally high costs or exceptionally long lengths of stay (as defined in sections IV.C. 2a. and 2b. of this Plan), are extended to services for children who have not reached the age of six, if provided by a hospital which qualifies as a disproportionate share hospital under Section 1923 (a) of the Social Security Act.

2. Amount of Payment Adjustment

a. The amount of funds allocated shall be twenty five thousand dollars ($ 25,000) for FY 2000. This includes Chronic/Rehabilitation, Psychiatric and State-Owned Nonacute hospitals

b. Any Hospital which qualifies for a payment adjustment for children under six, pursuant to IV.C.1. above shall receive one percent of the total funds allocated for such payments. In the event that the payments to qualifying non-State-Owned Chronic/Rehabilitation Hospitals would exceed the total, each share shall be proportionately reduced to stay within the allocation.

E. **Limits on Allocation of Funds.** The total amount on funds allocated for payment to non-State-Owned Chronic/Rehabilitation Hospitals may be proportionately reduced to stay within the federal DSH allotment limits for disproportionate share payments pursuant to 42 U.S.C. 1396r-4.